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COMMENTARY

A New Model to Facilitate Individualized Case Conceptualization and Treatment of Social Phobia: An Examination and Reaction to Moscovitch's Model

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Moscovitch's (2009) model of social phobia is put forth as an integration and extension of previous cognitive-behavioral models. The author asserts that his approach overcomes a number of shortcomings of previous models and will serve to better guide case conceptualization, treatment planning, and intervention implementation for clients with social phobia. Here I respond to these claims and examine the new and not-so-new aspects of Moscovitch's model. Moscovitch provides creative ways of thinking about feared stimuli and maladaptive methods for anxiety management used by clients with social phobia, and these notions may indeed expand our horizons, linking cognitive-behavioral thought to literatures on emotional suppression and emotion regulation. Other aspects of Moscovitch's thesis do provide heuristic and useful approaches to the assessment and treatment of social phobia which may be of great utility to the cognitive-behavioral clinician, but they do not provide a truly new approach to understanding the psychopathology or treatment of social phobia.

Social phobia is one of the most common mental disorders of our time (Kessler et al., 2005a; Kessler, Chiu, Demler, Merikangas, & Walters, 2005b), and it is associated with a variety other emotional and behavioral problems (e.g., depression, substance use) as well as substantial functional impairment (Katzelnick et al., 2001; Schneier et al., 1994) and life dissatisfaction (Eng, Coles, Heimberg, & Safren, 2005). Therefore, it is of great import that we develop maximally effective methods for assessment and treatment of social phobia. To facilitate that effort, several clinical researchers have put forth theoretical models of the disorder, working from the basic and unarguable premise that a better understanding of social phobia will enable us to develop better treatments for those who suffer so poignantly at its hands.

Theoretical models of social phobia have been put forth by Clark and Wells (1995; see also Clark, 2001) and Rapee and Heimberg (1997; see also Roth & Heimberg, 2001; Heimberg, Rapee, & Turk, 2002; Turk, Lerner, Heimberg, & Rapee, 2001), and these papers have stimulated a great deal of research into the understanding and psychological treatment of social phobia. Newer models have been put forth by Hofmann (2007) and Kimbrel (2008), but they have not been "on the scene" long enough to yet realize their significant potential.

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Moscovitch (2009-this issue) offers a new model of social phobia that he asserts improves over previous efforts. It is certainly the case that fresh works can help all interested parties to look at our old nemesis from a new perspective, to reconsider those tenets of our models that we and other researchers and clinicians have come to hold as self-evident, and, in so doing, to move farther ahead in our work to put the best possible treatments for our clients into place in the laboratory and the clinic. In that spirit, I offer the following comments and reactions.

Moscovitch (2009-this issue) suggests that his model improves on other models on several counts, and I will examine a number of his assertions in the remainder of this article. One of these is that current cognitive-behavioral models of social phobia have led to the development of treatments which have produced clinically significant change, but there are many clients who do not improve as much as desired. In fact, there is much truth to this, as there is for most every disorder we study, and we should always be looking to do better. However, the data that Moscovitch presents in support of the point may be viewed in various ways. He cites three studies, all of which evaluated a cognitive-behavioral group treatment of my design and creation (Heimberg et al., 1998; Otto et al., 2000) or one that is conceptually quite close to it (Davidson et al., 2004). Specifically, Moscovitch (2009-this issue) states that "results of intent-to-treat analyses from large clinical trials indicate that relatively few patients with social phobia (for example, 25% in Otto et al., 2000; 54% in Davidson et al., 2004; 58% in Heimberg et al., 1998) receiving "gold standard" (e.g.,

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Chambless & Ollendick, 2001) cognitive behavior therapy achieve high end-state functioning after acute treatment." I do not intend to argue that these numbers are good enough, because they are not, but it is important to understand what they truly mean. First, they are based on treatments designed in the 1990s, and there has been much attention paid to treatment development since that time (see below). Second, they are intent-to-treat analyses of categorical variables. In these analyses, dropouts or other participants whose data are missing are treated as failures in all-or-nothing fashion. Although these analyses are important to conduct for comparisons to other studies in the literature, they are flawed in the assumptions they make about missing data and the reasons why participants may choose to drop out of treatment, and they are less informative about client progress than more continuously distributed measures. Although intent-to-treat analyses have become more and more popular in the last decade, they do not reflect the degree of response to treatment that is demonstrated by participants who stay the course and are therefore exposed to the full dose of the treatment (independent variable), a question that is better answered by completer analyses (the same statistic from the completer analysis in Heimberg et al.'s study was 75%). Third, the meager 25% figure reported for Otto et al. reflects the fact that the criterion in that study was much more stringent — remission rather than response. Of course, we would like this number to be higher as well, but it is important to note that it is not comparable to the others. It is also important to keep in mind that, even with the most flexible treatments (see below), their implementation in randomized controlled trials will be constrained in ways that are not relevant to open clinical treatment. There are several recent studies that show these treatments to be effective when administered in clinical settings, and the results are most heartening (Gaston, Abbott, Rapee, & Neary, 2006; Lincoln et al., 2003; McEvoy, 2007).

Moscovitch (2009-this issue) gives scant mention to treatments that have been more recently developed based on the models of Clark and Wells (1995) or Rapee and Heimberg (1997). He briefly cites Clark et al.'s (2003) study of individual treatment of social phobia based on the Clark and Wells model, but he does not mention the several other studies that have come from that group or their collaborators (e.g., Clark et al., 2006; Mörtberg, Clark, Sundin, & Wistedt, 2007; Stangier, Heidenreich, Peitz, Lauterbach, & Clark, 2003). Neither does he mention the individual cognitive-behavioral therapy for social phobia developed by my group (Ledley et al., 2008; Hope, Heimberg, Juster, & Turk, 2000; Hope, Heimberg, & Turk, 2006; Turk, Heimberg, & Magee, 2008). Importantly, in mentioning ever so briefly the Clark et al. (2003) study, he describes it as a valuable effort to a develop a CBT framework that is specifically customized to the unique features of social phobia, and this is certainly the case for Clark (2003) as it is for all of the other studies cited above. He then states that he has presented a new model of case conceptualization and treatment that can be tailored to the specific features of individual clients with social phobia. This may or may not be true, but here it seems reasonable to argue a different point — that both Clark's and my group's treatment protocols are, in fact, quite substantially based on individualized case conceptualization and tailored to the specific features of individual clients.

Moscovitch (2009-this issue) cites Persons (2005), who tells us quite correctly that the best way to administer empirically supported treatments in clinical settings is to modify them based on the needs of the individual client. Persons has long been an advocate for the central role of case conceptualization in cognitive-behavioral treatment, and her words continue to be as wise today as when she first wrote about them 20 years ago (see Persons, 1989). Clark (2001) describes the several steps involved in his most creative approach to treatment. One of the very first activities is the development in collaboration with the client of an individualized case conceptualization based on the Clark and Wells model and which serves as the basis for much of the therapy activities that follow. Hope et al. (2000, 2006) do much the same, as exemplified in the case study described by Turk et al. (2008).

Our work speaks as well to Moscovitch's (2009-this issue) claim that current approaches to case conceptualization focus heavily and often exclusively on feared social situations. In our individual treatment (Hope et al., 2000, 2006), feared situations are indeed prominent. As many cognitive-behavioral therapists, we develop a fear and avoidance hierarchy with each client, and this is essentially a list of feared social situations. Situations *are* important because they are the "places" in which our clients live and because they are the stages in which the dramas of their social anxieties play out. However, to stop inquiry when we know what situations are feared would be to stop crossing the street before reaching the other side, and I know of few cognitive-behavioral therapists who would truly consider doing so. We ask many questions in the same spirit as those raised by Moscovitch — what are the features of social situations that make them feared by the client? What features make the anxiety better or worse? What are the client's (often automatic and distorted) thoughts about the nature of the situation to come? What does s/he think will happen as the situation unfolds? What (likely catastrophic) consequence does the client see as the more-or-less inevitable outcome of the situation? What is the consequence of the consequence? What does this mean about the client and his/her prospects of living a life in which goals of personal importance can be

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approached and attained? What strategies (avoidances, safety behaviors) does the client use in a maladaptive attempt to prevent perceived negative consequences and control anxiety? These are the kinds of questions that are asked of each client as we discuss each and every one of their feared situations, and as Moscovitch states several times, the answers to these types of questions do lead to different choices of intervention strategies. It is this approach to feared situations that allows us to understand what it is about them that is feared and what is the tie that binds topographically dissimilar situations together. In this way, situations may be thought of as “envelopes” that contain stimulus features of great importance along with the client's thoughts, feelings and behaviors about them. Thus, situations are the door to individualized case conceptualization per Persons (1989, 2005). What the therapist does with situations, in discussion with the client, in developing the case conceptualization, and in choosing intervention strategies, also differentiate the one who robotically implements a manualized treatment and the one who administers a manualized treatment with flexibility and creativity (Kendall, Chu, Gifford, Hayes, & Nauta, 1998).

A central question posed by Moscovitch (2009-this issue) is why different clients with social phobia often show markedly different responses to the same treatment. His response to the question is that the focus on situations keeps us from adequately conceptualizing client difficulties in a way that takes into account functional differences in clients' symptom profiles and that may lead to individualized treatment strategies. As is clear from the above, I do not see that this is the case, but even if we were to accept this premise for the moment, it becomes important to broaden one's case conceptualization beyond the kinds of variables that are discussed by Moscovitch or above. It is true that clients show vast differences in their response to the same therapy protocol, but even if we ignore some possible reasons such as the adequacy with which the therapy is delivered, there are a myriad of variables to consider that may have little to do directly with the client's social phobia. It is impossible to be comprehensive here (see Pontoski, Heimberg, Turk, & Coles, in press, for a review), but let me note just a few predictors of the outcome of treatment for social phobia which have not been discussed by Moscovitch (although I am certain that he would consider them highly relevant).

Severity of symptoms is a commonly recognized predictor of outcome (although it often appears in the guise of social phobia subtype or avoidant personality disorder, a controversial issue I will not engage here). It is a simple truth of cognitive-behavioral therapy for anxiety that we ask clients to do things that scare them, and the idea of treatment may itself just be too scary. Clients are also fearful that they will say something that will cause them to be embarrassed or humiliated in the process of assessment or treatment, and this concern has been listed as one of the primary variables that inhibits treatment seeking among persons with social phobia (Olfson et al., 2000). Once in therapy, they may have difficulty engaging in the treatment process for fear of the negative evaluation of the therapist. We have recently demonstrated that the client's evaluation of the therapeutic relationship affects the client's perception of the helpfulness of the therapy (Hayes, Hope, VanDyke, & Heimberg, 2007), so this is quite important to consider. Another well-established predictor of treatment outcome is the client's expectations (e.g., Safren, Heimberg, & Juster, 1997) — if the client does not expect to succeed, the chances are good that he or she will not. The reasons for this are legion and include being less willing to comply with homework assignments or engage in therapy activities when there is little belief that there will be a return on investment. Clients may also differ in the degree to which they are angry, depressed, engaged in problematic drinking or substance use, etc., and any of these aspects of the larger clinical picture may affect motivation to become involved in the most important activities of therapy — exposing oneself to key situations *in vivo* and doing so in a way that will allow the client to view the information contained in the experience which may provide disconfirmatory information about the feared situations or outcomes.

Relevant to individual differences in degree of motivation for therapy, a recent study with a mixed group of clients with social phobia, panic disorder, and generalized anxiety disorder examined the benefit of adding three sessions of motivational interviewing prior to group cognitive-behavioral therapy (Westra & Dozois, 2006). Individuals who received motivational interviewing, as compared to those who received no pretreatment intervention, showed an increase in positive expectancy for anxiety change before treatment, were more compliant with assigned homework during treatment, and were more likely to be responders. We have recently evaluated a combination of motivational enhancement and cognitive-behavioral therapy for a client with social phobia who drank alcohol to excess in order to control his anxiety and demonstrated reductions in both his social anxiety and his drinking behavior (Buckner, Ledley, Heimberg, & Schmidt, 2008). To return most squarely to the point to be made here, a complete case conceptualization for a client with social phobia must necessarily lead us outside the formal confines of his/her social phobia, to consider these (and other) personal and environmental circumstances that will certainly affect the course and outcome of treatment.

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Moscovitch (2009-this issue) asserts, and I agree, that maximizing the potential for positive outcomes in cognitive-behavioral therapy requires a precise understanding of the "nuanced manner in which every patient's anxious feelings, thoughts, and behaviors are functionally interrelated" (p. xx; this issue). This understanding can be facilitated by conducting a functional analysis, which according to Moscovitch's scheme would focus on: (1) feared stimulus — that which the patient perceives as being dangerous; (2) feared consequences — the outcomes that the patient is afraid will occur if the feared stimulus is confronted; (3) fear triggers and contexts; and (4) fear-related avoidance, escape, and safety behaviors. He refers to the totality of this assessment as the client's anxiety profile, which "varies uniquely across anxiety disorder diagnoses. For example, in panic disorder, anxiety is uniquely and primarily focused on somatic sensations; in OCD, on intrusive thoughts; in posttraumatic stress disorder, on traumatic memories…" (p. xx; this issue). I think there is much to like here, as a heuristic device that can assist clinicians in asking useful questions about their clients' concerns and aid in the development of case conceptualization. However, I wonder why it is necessary to stipulate that anxiety profiles vary uniquely across the anxiety disorder categories. First, this assumes that we have truly carved nature at its joints, something that my colleague of many years David Barlow has repeatedly told us is not the case. Second, social phobia does, in fact, feature a focus on somatic symptoms, intrusive thoughts, and traumatic memories, each described by Moscovitch as the sole province of other disorders. A couple of examples may be useful. A few years ago, we conducted a study of PTSD criterion A traumatic events and what we termed "socially stressful events" in a sample of clients with social phobia and control participants (Erwin, Heimberg, Marx, & Franklin, 2006). Socially stressful events were events that did not meet criterion A but which caused clients with social phobia great distress. Interestingly, the client sample satisfied the criteria for each of the PTSD symptom clusters in exactly the proportion required by the DSM-IV (American Psychiatric Association, 1994). Of course, most did not meet criteria for a diagnosis of PTSD because these were not criterion A events. However, the nature of criterion A events has been and continues to be a source of considerable controversy (see Rosen & Lilienfeld, 2008). Another, more clinical example is also enlightening. A client presented with intense social anxiety and avoidance. She was truly and deeply concerned with others' opinion of her and the idea that they would negatively evaluate her and ultimately want nothing to do with her, and she exhibited significant avoidance of social situations (other than those in which she could engage in specific safety behaviors or carry with her specific objects that would signal safety to her). However, her concerns were not specifically tied to the typical thoughts of persons with social phobia, but rather to the fear that she would blurt out socially unacceptable statements in an uncontrollable manner and at times when she might not even know that this had occurred. Further analysis, revealed this to be a most interesting example of intrusive thoughts in a clinical picture that seems best described as a hybrid between social phobia and obsessive compulsive disorder. Of course, the point here is that these anxiety profiles are not as distinct as Moscovitch portrays, and it is important to consider such "cross-overs" in case conceptualization. A final thought in this vein is that many of our clients have comorbid diagnoses, and these additional disorders affect the anxiety profile in significant ways. Consider, for instance, the study by Musa, Lépine, Clark, Mansell, and Ehlers (2003). Individuals with social phobia showed the oft-demonstrated attentional bias toward social threat; however, a group with social phobia and comorbid depression did not. In other words, the presence of depression suppressed attentional bias toward threat in the experimental task.

Existent models of social phobia suggest a number of fears that may be central to social phobia, including negative social evaluation, the loss of social rank or status, the inability to convey a desired social impression, and the emotional experience of embarrassment. However, Moscovitch (2009) contends that all of these conceptualizations are unsatisfactory because they confuse the feared stimulus with the feared consequences. It is truly useful to consider this viewpoint, but I wonder whether they are confounded in nature. It is the nature of the situation that dictates what the possible consequences might be (although a person with social phobia may think of different ones than someone without).

Moscovitch (2009-this issue) subdivides feared stimuli in social phobia into: (1) Perceived flaws in social skills and behaviors; (2) Perceived flaws in concealing potentially visible signs of anxiety; (3) Perceived flaws in physical appearance; and (4) Perceived characterological (i.e., personality-related) flaws. Clearly, these are areas of concern to many persons with social phobia, and it is quite reasonable to inquire about each of them when evaluating a new client. The largest contribution of this particular aspect of his model is similar to that of the list above — questioning in these areas will help the clinician to be thorough and comprehensive in his or her assessment and conceptualization. However, I do not believe that it will lead to more informed predictions than existent models, as these areas are part of most informed assessments of social phobia. As Moscovitch tells us, it is unclear whether these areas are distinct, and to his credit, he is taking an empirical approach to the investigation of that question.

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One of the most useful notions raised by Moscovitch (2009-this issue) is the idea that persons with social phobia fear "*characteristics of self that they perceive as being deficient or contrary to perceived societal expectations or norms*" (p. xx, italics in original) and that negative evaluation, rejection, embarrassment, and loss of social status are feared consequences that may occur if those self-attributes are exposed for scrutiny by critical others. It follows, as Moscovitch states, that "safety behaviors are self-protective, self-concealment strategies that serve the intended function of preventing the public exposure and criticism of feared self-attributes" (p. xx; this issue). In every good paper, there are a few nuggets that are truly worth the investment of reading effort, and these assertions bring a new perspective to the understanding of both anxiety and coping in social phobia. Not only do these ways of viewing feared stimuli, feared consequences, and safety behaviors open up a myriad of new research questions, but they link cognitive-behavioral models to emerging research on suppression of emotional expression and limited self disclosure in social phobia/social anxiety.

To flesh out the previous statement a bit, several studies have demonstrated that socially anxious individuals tend to limit self-disclosure in conversations, especially under conditions of evaluative threat (Alden & Bieling, 1998; DePaulo, Epstein, & LeMay, 1990; Leary, Knight, & Johnson, 1987; Meleshko & Alden, 1993; Snell, 1989). Furthermore, this suppression becomes more pronounced when the socially anxious person expects to be evaluated. For instance, DePaulo et al. (1990) found that socially anxious individuals who expected to be evaluated by an interviewer told shorter, less revealing stories about themselves and chose topics about more commonplace events than controls or socially anxious individuals who did not expect to be evaluated. Alden and Bieling (1998) found that when socially anxious individuals focused on the critical nature of a role-play confederate, they disclosed information about less intimate topics than did non-socially anxious individuals. Other studies suggest that social anxiety is associated with an interpersonal style characterized by an avoidance of expressing emotion (Davila & Beck, 2002; Grant, Beck, Farrow, & Davila, 2007) and a general tendency to inhibit or controls the expression of emotions (Kashdan & Breen, 2008). Although individuals with social phobia reported higher levels of angry feelings than controls, they also reported more suppression of their expression of anger (Erwin, Heimberg, Schneier, & Liebowitz, 2003). None of this should be too surprising given our recent finding that socially anxious persons believe that expression of emotions is a sign of weakness and will be met with social rejection (Spokas, Luterek, & Heimberg, in press). However, Moscovitch's (2009-this issue) ideas and these studies of the strategies social anxious persons use to manage their fears potentially put our thinking about social phobia into a new context, that of emotion regulation, a rich literature which has hardly been tapped in relation to the anxiety disorders.

Moscovitch (2009-this issue) concludes the presentation of his model with a list of five specific recommendations for the improvement of the treatment of social phobia:

1. Carefully assess anxiety symptom profiles;
2. In therapy, shift the emphasis from situational exposure to dimension-specific self-exposure;
3. Develop creative strategies for promoting self-exposure and eliminating self-concealment;
4. Challenge patients' misperceptions of social norms and the inflated costs of violating them, and
5. Challenge patients' misperceptions of the critical audience observer.

All of these are good ideas and should be considered part of the treatment of many, if not most, persons with social phobia. Applying these strategies in the context of Moscovitch's creative notions about the role of self-concealment in social phobia will be most helpful. However, I come to the end of this list and wonder what about these ideas is new. Many of us have been using all five of these strategies for some time. Moscovitch's thesis certainly reinforces those ideas, and we are all the more likely to continue to do so.

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